



# Accident Report Packet

This packet contains information which provides both the employee and supervisor with the required forms, process and procedures to ensure appropriate notifications, communication and case management occurs in an ongoing and timely manner in the event of a workers' compensation claim. Injuries must be reported within 48 hours.

## *Employee*

- ✓ Employee's Responsibilities
- ✓ Injured Worker's Timeline
- ✓ Panel of Physicians
- ✓ Employee's Report of Injury
- ✓ Authorization for Medical Treatment
- ✓ Wells Fargo Disability Mgmt Billing Information
- ✓ Medical Treatment and Work Status Form
- ✓ Family/Medical Leave (FMLA)
- ✓ Long-term Disability
- ✓ Employee Assistance Program

## *Supervisor*

- ✓ Supervisor's Responsibilities
- ✓ Employer's Report of Injury

## *Contact Information*

Tom Chunta, Workers' Compensation Coordinator  
703.777.0214

Barbara Wooten, Benefits Assistant (*FMLA*)  
703.771.5970

Wells Fargo Disability Management  
877.371.9700, x6044



# **Employee's Responsibilities**

## **Quick Reference Guide**

- 1) To report a work related incident you must complete the enclosed ***Employee's Report of Injury*** along with your supervisor.
- 2) The County (in accordance with State guidelines) requires that any employee/volunteer that is injured during work or volunteer activity is to choose from a ***Panel of Physicians*** provided in this packet. Once you choose a physician from the panel, you cannot change that physician without prior approval from Wells Fargo Disability Management at 1.877.371.9700, ext 6044, or Tom Chunta, Loudoun County's Workers' Compensation Coordinator at 703.777.0214. Failure to use an approved physician will result in non-payment of all medical bills relating to this injury /illness.
- 3) If you go to an emergency facility and they refer you to your "family physician", you **must** choose a physician from the panel. If your family physician is on the panel, you may see him/her.
- 4) Once seen by the treating physician, you must have them complete a ***Medical Treatment and Work Status*** form and return it to your supervisor or Tom Chunta, Workers' Compensation Coordinator, in the Benefits Department. If you have been instructed to make a follow-up appointment with a specialist, you must again choose from the ***Panel of Physicians - Specialty*** and take a ***Medical Treatment and Work Status*** form with you to each doctor's appointment that you may have.
- 5) You must present the enclosed ***Wells Fargo Disability Management*** billing information to the medical provider or facility to insure the correct billing. Failure to do so may result in medical bills for services being sent directly to you.  
**IMPORTANT NOTE:** Do **not** present your health insurance plan ID card for services involving a work related injury or illness. If you are prescribed medication, you may get the prescription filled at Leesburg Pharmacy. They will verify it was a work related injury and bill Wells Fargo accordingly. If you utilize another pharmacy, you may be required to pay out of pocket for the prescription. You will need to forward the original register receipt, in addition to the prescription receipt attached to the bag, to the County's Workers' Compensation Coordinator for reimbursement.
- 6) Any absence from work must be substantiated by an off work certificate from a panel physician. Benefits will become effective on the first day of absence as a result of the injury/occupational disease. The injured employee will receive injury leave in addition to workers' compensation for the remainder of his/her normal work week schedule after the initial day of injury.
- 7) If you lose time from work due to this injury/illness, you must keep the County's Workers' Compensation Coordinator informed, as well as your supervisor and/or Department Head in accordance with your departmental protocol, as to your progress

toward recovery and when you may expect to return to work. Along with this, the absence must be substantiated by a certificate from your treating physician stating the expected disability period. You must obtain a copy of your most recent performance plan from your supervisor to provide to your treating physician on your follow-up appointment. Prior to returning to work, a doctor's certificate must be presented to your supervisor with a copy to the County's Workers' Compensation Coordinator stating you have been released to return to work status, any limitations, and the effective date of that release.

- 8) Lost time due to a workers' compensation illness or injury, whether paid or unpaid, runs concurrent with leave under the Family and Medical Leave Act (FMLA). Please refer to the enclosed for more information and instructions for completing the necessary paperwork for FMLA. Completed forms should be forwarded to Barbara Wooten in the Benefits Department.
- 9) If you are required to have a Fitness-for-Duty exam (i.e. public safety) by a County physician, you must schedule an appointment prior to your return to work. It is your responsibility to provide the County physician with a copy of your medical file from the workers' comp treating physician. Failure to do so may result in a delay of your return to work. Once you have been released by the workers' comp physician, both workers' comp benefits and injury leave cease.
- 10) Employees are required to file for Long-term Disability within the elimination period of 60 days in order to maintain eligibility for injury leave. Injury leave is available for a maximum of 26 calendar weeks within a 12 month period from the date of initial injury or the date the employee first began missing work. Contact Hartford at 1.800.303.9744 or Robin York, Benefits Coordinator, 703.771.5785 for more information or assistance.
- 11) You must sign and return the enclosed ***Authorization for Medical Treatment*** to the attention of Tom Chunta, Workers' Compensation Coordinator immediately upon receipt thereof.
- 12) A copy of all medical correspondence must be provided to the County's Workers' Compensation Coordinator for claims processing.
- 13) Failure to provide information required to the County's Workers' Compensation Coordinator will result in the suspension of injury leave benefits.
- 14) Failure to comply with Workers' Compensation guidelines will result in the suspension of Workers' Compensation benefits in addition to injury leave.
- 15) Failure to return to work when able to do so will result not only in suspension of injury leave, but also all workers' compensation benefits for this injury/illness.

Please take the time to thoroughly read and sign (as required) all of the information in this packet. If you should have any questions, please contact Tom Chunta, Workers' Compensation Coordinator at 703.777.0214. You should also consult your HR representative and/or the County's HR Policy Handbook to better understand your responsibilities with regard to your leave.



## Injured Workers Timeline

- ✓ **Day 3-** If you are going to be out more than 3 days, you are encouraged to file for FMLA. Doing so protects your rights to be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment upon your return prior to the expiration of this time in accordance with Federal Law and County policy. Additional information and forms are included within this packet or by going to [www.loudoun.gov](http://www.loudoun.gov) select "employee", FMLA forms. Complete and return to Barbara Wooten in the Benefits Department. If you have questions please contact the Barbara Wooten, Benefits Assistant at 703.771.5970.
- ✓ **Day 7 and every 7 days-** If you continue out of work, you must check in with your immediate supervisor and/or Tom Chunta, Workers' Compensation Coordinator in the Benefits Department for an update on your condition. It is your responsibility to keep your department informed of your progress.
- ✓ **Day 30-** If at day 30, it looks as though you are going to be out of work longer than 60 days, you are required to file for Long-term Disability benefits (LTD). Per HR Handbook section 6.4.07, the policy states "the employee is required to file for long-term disability within the elimination period of 60 days in order to maintain eligibility for injury leave". Contact Hartford at 1.800.303.9744 or Robin York, Benefits Coordinator, 703.771.5785 for assistance.
- ✓ **Day 61-** In order to maintain eligibility for injury leave you must have filed for LTD at this point.
- ✓ **Week 26-** Injury leave can only remain in effect for up to 26 weeks. If you still remain off work, you will continue to be eligible for a benefit of 66 2/3 from Workers' Compensation and a benefit to be determined from our LTD Carrier (Hartford).



## **Panel of Physicians – Primary Care**

***\*\*\*IF medical emergency, please report to closest Emergency Room.\*\*\****

### ***Business Health Services***

2000 Foundation Way #2200  
Martinsburg, WV 25401  
(304) 264-1247

### ***Amherst Family Practice***

1867 Amherst St.  
Winchester VA. 22601  
(540) 667-8724

### ***Inova Urgent Care***

Centerville (703) 830-5600 (6201 Centerville Rd Suite 200)  
Vienna (703) 938-5300 (100 Maple Ave East)  
Reston (703) 668-28323 (11901 Baron Cameron Ave)  
Alexandria (703) 838-5530 (225 Reinekers Ln)

### ***NOVA Urgent Care***

Leesburg (703) 777-9701 (51 Catoctin Circle, N.E.(Leesburg Plaza)  
Ashburn (703) 554-1111 (21785 Filigree Court, Suite 100)  
Sterling (703) 430-4343 (21036 Triple Seven Rd)  
Warrenton (540) 347-0400 (528 Waterloo Rd)

### ***Concentra***

Sterling (703) 435-7656 (45305 Catalina Ct, Suite 103)  
Alexandria (703) 914-6718 (5590 General Washington Drive)

### ***IMPORTANT NOTICE:***

The County (in accordance with State guidelines) requires that any employee/volunteer that is injured during work or volunteer activity is to choose from a ***Panel of Physicians***. Once you choose a physician from the panel above, you cannot change that physician without prior approval from Wells Fargo Disability Management Loudoun County's Workers' Compensation Coordinator. If a panel physician refers you to a specialist, it is the employee/volunteer's responsibility to insure that the specialist is on the ***Specialty Panel of Physicians***. Failure to use an approved physician will result in non-payment of all medical bills relating to this injury/illness.



## **Panel of Physicians – Specialty**

**You must have been referred by a practice from the Primary Care  
Panel of Physicians or hospital emergency room doctor  
to be seen by any of the specialists below.**

### **General Orthopedic**

Dr. Jeffrey Berg  
Town Center Orthopedic Associates, P.C.  
1860 Town Center Drive, Suite 300  
Reston, VA 20190  
(703)435-6605

Dr. Raymond Thal  
Town Center Orthopedic Associates, P.C.  
1860 Town Center Drive, Suite 300  
Reston, VA 20190  
(703)435-6605

Dr. Randolph Cook  
Center for Advanced Orthopedics & Pain Management  
21785 Filigree Court, Suite 103  
Ashburn, VA 20147-5214  
(703)444-5447

Dr. Angela Santini  
Virginia Spine and Sports Orthopedics  
19450 Deerfield Avenue, Suite 175  
Lansdowne, Virginia 20176  
(703)858-5454

Dr. Paul Mecherikunnel  
107 E. Holly Street  
Sterling, VA 20164  
(703)435-5510

Dr. Robert Dombrowski  
Commonwealth Orthopedics  
13350 Franklin Farm Road, Suite 220  
Herndon, VA 20171  
(703)471-5300

Dr. George Aguiar (Speaks Spanish)  
Commonwealth Orthopedics  
1850 Town Center Drive, Suite 400  
Reston, VA 20190  
(703)435-6605

**Orthopedic Spine Specialist**

Dr. Angela Santini  
Virginia Spine and Sports Orthopedics  
19450 Deerfield Avenue, Suite 175  
Lansdowne, Virginia 20176  
(703)858-5454

Dr. Ian Wattenmaker  
Town Center Orthopedic Associates, P.C.  
1860 Town Center Drive, Suite 300  
Reston, VA 20190  
Or  
19C Fort Evans Road, N.E.  
Leesburg, VA 20176  
(703)435-6605

Dr. Tushar Patel  
Commonwealth Orthopedics  
13350 Franklin Farm Road, Suite 220  
Herndon, VA 20171  
(703)471-5300

**Orthopedic Upper Extremity Specialist**

Dr. Paul Mecherikunnel  
107 E. Holly Street  
Sterling, VA 20164  
(703)435-5510

Dr. J. Mark Evans  
Commonwealth Orthopedics  
8501 Arlington Blvd., Suite 400  
Fairfax, VA 22031-4625  
(703)573-7168

Dr. David R. Miller  
Town Center Orthopedic Associates, P.C.  
1860 Town Center Drive, Suite 300  
Reston, VA 20190  
(703)435-6605

### **Orthopedic Foot Specialist**

Dr. George Kartalian  
Town Center Orthopedic Associates, P.C.  
1860 Town Center Drive, Suite 300  
Reston, VA 20190  
(703)435-6605

### **Orthopedic Shoulder/Knee Specialist**

Dr. Robert Dombrowski  
Commonwealth Orthopedics  
13350 Franklin Farm Road, Suite 220  
Herndon, VA 20171  
(703)471-5300

Dr. Raymond Thal  
Town Center Orthopedic Associates, P.C.  
1860 Town Center Drive, Suite 300  
Reston, VA 20190  
(703)435-6605

Dr. Randolph Cook  
Center for Advanced Orthopedics & Pain Management  
21785 Filigree Court, Suite 103  
Ashburn, VA 20147-5214  
(703)444-5447

### **Physiatry**

Dr. Stephanie Clop  
Town Center Orthopedic Associates, P.C.  
1860 Town Center Drive, Suite 300  
Reston, VA 20190  
(703)435-6605

Dr. Virgil A. Balint  
Capital Spine & Pain Center  
150 Elden Street, 240  
Herndon, VA 20170-4845  
(703)709-0832

Dr. Ali G. Ganjei  
INOVA Fair Oaks Hospital  
3600 Joseph Siewick Drive  
Fairfax, VA 22033-1709  
(703)698-6155

### **Neurosurgery**

Dr. Charles J. Azzam  
3301 Woodburn Road, Suite 105  
Annandale, VA 22003  
(703)205-6210

Dr. Donald Hope  
Center for Cranial & Spinal Surgery  
1830 Town Center Drive, Suite 103  
Reston, VA 20190  
(703)560-1146

Dr. Sean A. Jebraili  
2750 Prosperity Ave., Suite #120  
Fairfax, VA 22031-4336  
(703)698-6155

### **Non-Surgical Pain Management**

Dr. Virgil A. Balint  
Capital Spine & Pain Center  
150 Elden Street, 240  
Herndon, VA 20170-4845  
(703)709-0832

Dr. Sassan Hassassian  
Center for Advanced Orthopedics & Pain Management  
21785 Filigree Court, Suite 103  
Ashburn, VA 20147-5214  
(703)444-5447



## Loudoun County, Virginia

[www.loudoun.gov](http://www.loudoun.gov)

Management and Financial Services, Human Resources / Benefits  
1 Harrison St., SE, 4<sup>th</sup> Floor, MS #41A Leesburg, VA 20177-7000  
Telephone (703) 777-0517 • Fax (571) 258-3212

### Employee's Report of Injury

Instructions-Employee: Please complete this report and return to your supervisor. Supervisor: Review incident with employee and then enter the required information onto the Employer's Accident Report. Send both original injury reports to the Workers' Comp dept. within 48 hours.

Name (First, Middle, Last) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No. \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Job Title \_\_\_\_\_ Department \_\_\_\_\_

Injury Date \_\_\_\_\_ Time of Injury \_\_\_\_\_ Overtime Yes/No Last Day Worked \_\_\_\_\_

Date Supervisor Notified \_\_\_\_\_ Date Returned to Work \_\_\_\_\_

#### **What was the injury or illness?**

State exact part of the body affected and what the injury or illness was.

Injury \_\_\_\_\_

Body Part \_\_\_\_\_ Specific Area \_\_\_\_\_ Please Circle: Left Right N/A

#### **What were you doing just before the incident occurred?**

Describe the activity, as well as the tools, equipment or material you were using. Be Specific. Example: "Arresting subject."

#### **How did the injury/illness occur?**

Example: "While arresting subject, fell to the ground and landed on arm."

**Where did the incident happen?** \_\_\_\_\_

**What can be done to prevent future occurrence?** \_\_\_\_\_

**Where did you go for medical treatment?** \_\_\_\_\_ N/A

I certify that the information in this Work-Related Injury Report is true and accurate to the best of my knowledge. I understand that the County will rely upon this form in evaluating my claim. I further understand that this document may be presented or used in support of or against a claim for payment under the County's policy of workers' compensation insurance. I understand falsification of any information on or about this injury report form or the alleged injury, and the assertion of a false workers' compensation claim, are violations of Virginia's Criminal laws, may result in a fine and imprisonment and/or termination of my employment.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date \_\_\_\_\_



## Authorization for Medical Treatment & Disclosure

Employee: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_  
Department: \_\_\_\_\_

RE: Date of Injury: \_\_\_\_\_  
Claim No.: \_\_\_\_\_

### To Whom It May Concern:

I hereby request and authorize you to disclose, whenever requested to do so by the County of Loudoun or its representative, any and all information you may have concerning:

\_\_\_\_\_  
(Specify illness or injury)

Or any illness or injury, medical history, consultation, prescription or treatment, including x-rays and copies of all hospital records and Health Department records. A photocopy of this authorization shall be considered as effective and valid as the original.

I have read and understand my responsibilities relating to my workers' comp claim. I acknowledge that I have received a copy of the Loudoun County Government Panel of Physicians and Notice of my FMLA Rights and Responsibilities.

Employee's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date \_\_\_\_\_

=====

Please list below all physician's names and address that you have seen whose treatment pertains to the above-reference injury/illness:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return this form to Tom Chunta, Workers' Compensation Coordinator,  
Department of Management and Financial Services, Human Resources/Benefits.  
Fax # 571.258.3212.

# GIVE TO MEDICAL PROVIDER



## Workers' Compensation Billing Information

Wells Fargo Disability Management  
353 Falls Drive, Post Office Box 1567  
Abingdon, Virginia 24210  
Claim Rep: Matt Akins, 1-877-371-9700 ext 6044

Loudoun County Rep: Tom Chunta, 703-777-0214

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# GIVE TO MEDICAL PROVIDER



## Workers' Compensation Billing Information

Wells Fargo Disability Management  
353 Falls Drive, Post Office Box 1567  
Abingdon, Virginia 24210  
Claim Rep: Matt Akins, 1-877-371-9700 ext 6044

Loudoun County Rep: Tom Chunta, 703-777-0214



## **Workers' Compensation Billing & Contact Information**

Wells Fargo Disability Management  
353 Falls Drive, Suite C, P.O. Box 1567  
Abington, Virginia 24210

Claim Rep: Matt Akins, 1-877-371-9700 ext 6044  
Sr. Claims Rep: Karen Johnson, 1-877-371-9700 ext 6047

Loudoun County Rep: Tom Chunta, 703-777-0214  
[Tom.Chunta@loudoun.gov](mailto:Tom.Chunta@loudoun.gov)



# Loudoun County, Virginia

www.loudoun.gov

Department of Management and Financial Services/Workers' Compensation Program  
1 Harrison Street, S.E., 4th Floor, Mail Stop 41-A, P.O. Box 7000, Leesburg, VA 20177-7000  
Phone 703.777.0214 • Fax 571.258.3212

3<sup>rd</sup> Party Administrator: Wells Fargo Disability Management  
353 Falls Drive, P.O. Box 1567  
Abingdon, VA 24212  
Phone: 877.371.9700, Fax: 276.676.0152

## MEDICAL TREATMENT & WORK STATUS FORM

### To be Completed by Employee (Employee Signature Required)

Name: \_\_\_\_\_ SS #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Phone: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

*I give permission to my physicians or other healthcare providers, hospitals, or clinics to release the information on this form and to release my medical records relating to this injury/illness to my employer, Wells Fargo Disability Management, and any entity responsible for providing services in connection with my workers' compensation claim. I understand this information will be used to assist my employer in evaluating my injury/illness, my work status, and proposed courses of treatment.*

Date \_\_\_\_\_ Employee's Signature \_\_\_\_\_

### To be Completed by Healthcare Provider

☐ Check if treatment completed ☐ New Injury/or  
Patient has follow-up appointment on: \_\_\_\_\_ ☐ Aggravation of pre-existing injury  
Diagnosis: \_\_\_\_\_  
Treatment (including surgery, physical therapy, medications, and diagnostic procedures, new injury or aggravation of pre-existing injury) \_\_\_\_\_

### Medical Recommendations for Return to Work: Modified duty may be available for all employees

#### Work Status: (Health Care Provider, please check all appropriate boxes)

- ☐ Patient released to regular duty on \_\_\_\_\_ or ☐ Patient expected to return to full duty on \_\_\_\_\_  
☐ Patient may work transitional/modified duty as of \_\_\_\_\_ with restrictions as listed below:  
Unable to work \_\_\_\_\_
- |   |  |
|---|--|
| <input type="checkbox"/> Sedentary: lift/carry 10# maximum: walk, stand, sit as needed  | <input type="checkbox"/> Endurance abilities: _____ hour/shift |
| <input type="checkbox"/> Light: lift/carry occasional 20# maximum; sitting as needed, may lift/carry up to 10# frequently, walk stand, push, pull (arm or leg controls), may walk/stand to significant degree | <input type="checkbox"/> No reaching above shoulder height     |
| <input type="checkbox"/> Light Medium: lift/carry occasional 35# maximum, frequently lift/carry up to 20#   | <input type="checkbox"/> No reaching below waist               |
| <input type="checkbox"/> Medium: lift/carry occasional 50# maximum, frequently lift/carry up to 25#   | <input type="checkbox"/> No exposure to dust/fumes             |
| <input type="checkbox"/> Medium Heavy: lift/carry occasional 75# maximum, frequently lift/carry up to 50#   | <input type="checkbox"/> Dry work only                         |
| <input type="checkbox"/> Heavy: lift/carry occasional 100# maximum, frequently lift/carry up to 50#   | <input type="checkbox"/> No operating machinery/vehicles       |
| <input type="checkbox"/> Very heavy: lift/carry occasional >100#.max: 50lbs or less frequently  |  |

Signature of Healthcare Provider \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Please return form to Loudoun County, Department of Mgt & Financial Services, Human Resources/Benefits, Attn: Tom Chunta, Workers' Compensation Coordinator, Phone 703.777.0214 / Fax 571.258.3212.



## County of Loudoun, VA

# FMLA Rights and Responsibilities

Except as explained below, you may have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period for the reasons listed as indicated on the ***Request for Family or Medical Leave***. Your health benefits will be maintained during any period of unpaid leave under the same conditions as if you continued to work. You will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment upon your return prior to the expiration of this time. If you do not return to work following FMLA leave for a reason other than: (1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; or (2) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.

Family / Medical leave will be granted in accordance with federal and state law as well as County policy. You may be eligible for leave under FMLA if you have worked for the County of Loudoun for at least 12 months and worked a minimum of 1,040 hours in the preceding 12 month period. You will need to complete a ***Request for Family or Medical Leave*** and ask your doctor to complete the ***Certification of Health Care Provider***. You must furnish medical certification to Human Resources / Benefits within 15 days after you receive this notice or your leave may be delayed or denied until the certification is submitted.

1. The leave will be unpaid unless you have designated available paid leave. In the case of disability, payment may occur in accordance with the County's disability plan.
  - a) If your leave is unpaid and you wish to continue benefits coverage during your leave, you should make arrangements for payment of premiums. This payment is due on or before the 10<sup>th</sup> of the month in which you would otherwise have paid such contributions by payroll deduction. If a check is returned for insufficient funds, the County may consider that as a failure to make payment. Please refer to the ***Notice Regarding Continued Health Insurance Coverage***.
  - b) You have a 30-day grace period in which to make payment. If payment is not timely made, your group health insurance or other benefits may be canceled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse.
2. You may be required to furnish us with periodic medical recertification upon request, as often as every 30 days, relating to the serious health condition.
3. You will be required to furnish us with periodic reports of your status and intent to return to work every 30 days while on FMLA leave. If the circumstances of your leave change and you are able to return to work earlier than the date indicated on this form, you must notify us at least two work days prior to the date you intend to report to work. If you fail to return to work or contact the County by the expected return date, it will be considered that you abandoned your job and employment may be terminated.
4. You will be required to present a ***Return to Work Certification*** prior to returning to work at the end of your leave. If such certification is required but not received, your return to work may be delayed until certification is provided.
5. If you are considered a "key employee" by the Department of Labor, as described in Section 825.218 of the FMLA regulations, restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us as discussed in 825.218.

Any questions concerning your leave should be directed to Human Resources / Benefits, 703.777.0517.

#### Additional References:

Human Resources Handbook, section 6.4.02

Administrative Policies and Procedures – FMLA, HR-18



## County of Loudoun, VA Request for Family or Medical Leave

TO BE COMPLETED BY EMPLOYEE  
(Copy to Benefits/Human Resources and Department Head)

Request for Family or Medical leave *must be made at least 30 days prior to the date the requested leave is to begin*. If the need for leave is *unforeseeable*, the request should be submitted as soon as practical. Eligible employees must have been employed for *12 months* and have worked *1,040 hours* in the 12 months period prior to the start of the requested leave.

Employee Name (Please print) \_\_\_\_\_

Date of Request \_\_\_\_\_

Address \_\_\_\_\_

Department Head's Name & Dept. \_\_\_\_\_

### Reason for Request

- \_\_\_ the birth of a child, or the placement of a child for adoption or foster care;  
\_\_\_ your serious health condition (including complications of pregnancy); or  
\_\_\_ a serious health condition affecting,  
your spouse \_\_\_, child \_\_\_, or parent \_\_\_, for whom you are needed to provide care.

Beginning Date of Requested Leave: \_\_\_\_\_ Expected Date of Return: \_\_\_\_\_

For birth of a child, provide estimated date of delivery: \_\_\_\_\_

For adoption or foster care, provide estimated date of placement: \_\_\_\_\_

Spouse is employee of Loudoun County Government: ☐ YES ☐ NO

Total Number of Weeks Requested: \_\_\_\_\_

Total Number of Hours / Days (*if intermittent only*): \_\_\_\_\_

Family Member's Name and Relationship (if applicable): \_\_\_\_\_

*Please give specific details of your reason for requesting leave.* If you are taking leave to care for a seriously ill family member, state the care you will provide and an estimate of the time period during which this care will be provided:

\_\_\_\_\_  
\_\_\_\_\_

**Intermittent or Reduced Schedule**

If you are requesting leave on ***an intermittent or reduced schedule***, please describe your needed leave below (i.e. doctor's appointments, physical therapy, etc.). Intermittent or reduced schedule leave may be taken due to your own serious health condition or to care for a spouse, child or parent with a serious health condition.

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You must designate the amount and types of your accrued leave to be used while on approved FMLA.

|                          | <u>Hours / Day</u> | <u>Weeks</u> |
|--------------------------|--------------------|--------------|
| Earned Sick Leave        | _____              | _____        |
| Earned Annual / Personal | _____              | _____        |
| Leave Without Pay        | _____              | _____        |
| *TOTAL                   | _____              | _____        |

**IMPORTANT NOTE:**

FMLA includes both paid and unpaid leave, vacation and/or sick leave and runs concurrent with workers compensation and disability.

\*Total should equal total amount of leave requested. 1 week = 7 days (workweek is Thurs – Wed) FMLA = 12 weeks

*This Request for Family or Medical Leave must be submitted to Human Resources / Benefits along with the appropriate documentation.*

If your request is for your own serious health condition or the serious health condition\* of your spouse, child or parent, you must submit a **Certification of Health Care Provider** from the treating physician ***within 15 days of the application for leave.***

(If your request is for the ***birth, adoption, or foster care placement of a child***, documentation of this event ***may*** be required.)

\*Serious Health Condition – refer to Certification of Health Care Provider for definition.

**I certify that the information given on this form is true. I understand that making false statements on this form is grounds for discipline up to and including termination of my employment. I further understand that a failure to return to work at the end of my approved leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Loudoun County. A copy of this form has been provided to my Department Head.**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date



County of Loudoun, VA  
Certification of Health Care Provider  
Family and Medical Leave Act of 1993

To be completed by the treating physician  
and submitted to Benefits/Human Resources.

1. Employee's Name: \_\_\_\_\_

2. Patient's Name (if different from employee): \_\_\_\_\_

3. Does the patient's condition<sup>1</sup> qualify as a "serious health condition" under any of the categories described?  
If so, please check the applicable category.

"Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

\_\_\_ a. **Hospital Care:** Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity<sup>2</sup> or subsequent treatment in connection with or consequent to such inpatient care.

\_\_\_ b. **Absence Plus Treatment:** A period of incapacity<sup>2</sup> of more than three consecutive calendar days (including any subsequent treatment or period of incapacity<sup>2</sup> relating to the condition) that also involves:

(1) Treatment<sup>3</sup> two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment<sup>4</sup> under the supervision of the health care provider.

\_\_\_ c. **Pregnancy:** any period of incapacity due to complications of pregnancy or for prenatal care.

\_\_\_ d. **Chronic Condition Requiring Treatments:**

(1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity<sup>2</sup> (e.g., asthma, diabetes, epilepsy, etc.).

\_\_\_ e. **Permanent/Long-Term Condition Requiring Supervision:** A period of incapacity<sup>2</sup> which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but not need be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

\_\_\_ f. **Multiple Treatments (Non-Chronic Conditions):** Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity<sup>2</sup> of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

\_\_\_ g. **None of the Above:**

4. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of the above marked category: \_\_\_\_\_

continued next page

<sup>1</sup> The information sought on this form relates only to the condition for which the employee is taking FMLA leave.

<sup>2</sup> "Incapacity" for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

<sup>3</sup> "Treatment" includes examinations to determine if a serious health condition exists and evaluations of the condition. "Treatment" does not include routine physical examinations, eye examinations, or dental examinations.

<sup>4</sup> A "regimen of continuing treatment" includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bedrest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

5. a. Approximate Date the Condition *Commenced*: \_\_\_\_\_  
b. Probable *Duration* of the Condition: \_\_\_\_\_ c. Probable Duration of the Patient's present incapacity<sup>2</sup>, if different: \_\_\_\_\_

d. Will it be necessary for the employee to take leave *only intermittently* or to work on *less than full schedule* as a result of the condition (including for treatment described in Item 6 below)?

\_\_\_ Yes \_\_\_ No Probable Duration: From \_\_\_\_\_ To \_\_\_\_\_

e. If the condition is a *chronic condition* (as defined in 3.d., above) or pregnancy (as defined in 3.c., above):

Is the patient presently *incapacitated*<sup>2</sup>? \_\_\_ Yes \_\_\_ No

What is the likely *duration* and frequency of episodes of incapacity<sup>2</sup>: From \_\_\_\_\_ To \_\_\_\_\_

6. Regimen of Treatment:

- a. If additional treatments will be required for the condition, provide an estimate of the probable number of treatments, general nature and duration of treatment and the period required for recovery, if any. Include a schedule of visits or treatment (actual or estimated dates of treatment, if known), if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week. \_\_\_\_\_
- b. If any of these treatments will be provided by *another* provider of health services (e.g., a physical therapist), please state the nature of the treatments: \_\_\_\_\_
- c. If a *regimen* of continuing treatment (as defined in note 4 above) by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment): \_\_\_\_\_

7. EMPLOYEE'S CONDITION (*absence from work*)

- a. If medical leave is required for the employee's *absence from work* because of the employee's own condition (including pregnancy or a chronic condition), is the employee unable to perform work of any kind? \_\_\_ Yes \_\_\_ No \_\_\_ N/A
- b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.) \_\_\_ Yes \_\_\_ No \_\_\_ N/A
- If yes, please list the essential functions the employee is unable to perform: \_\_\_\_\_
- c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? \_\_\_ Yes \_\_\_ No

8. FAMILY MEMBER'S CONDITION

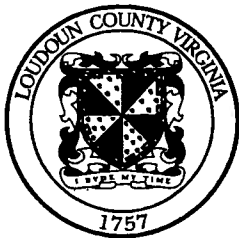
- a. If leave is required to *care for a family member* of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? \_\_\_ Yes \_\_\_ No
- b. If no, would the employee's presence to provide *psychological comfort* be beneficial to the patient or assist in the patient's recovery? \_\_\_ Yes \_\_\_ No
- c. Estimate the period of time care is needed or time the *employee's presence would be beneficial*:  
From \_\_\_\_\_ To \_\_\_\_\_
- d. If the patient will need care only *intermittently* or on a *part-time* basis, please indicate the probable duration of this need:  
From \_\_\_\_\_ To \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Address/Phone Number

\_\_\_\_\_  
Date



## RETURN TO WORK CERTIFICATION

Physician certification for return to work is required in the following situations.

- Before the employee reports for duty after a medical absence.
- Whether the return to work is earlier than originally indicated by treating physician, or as indicated in the initial medical certification, and / or
- Limited duty is a return to work condition.

\_\_\_\_\_(Employee Name) has been under my care because of a serious health condition that rendered the employee unable to perform the essential functions of his / her position. Currently, the employee is scheduled to return to work on \_\_\_\_\_. However, before the employee will be permitted to return to work, it is my understanding that the employee must submit a medical certification that they are able to return to work. This certification relates only to the particular health condition that caused the employee's need for medical leave.

I hereby certify that the employee is now able to perform the essential functions of his / her position and may return to employment in that or a similar position.

If there are limitations that prevent the employee from returning to work full-duty at this time, I have indicated those restrictions in detail below.

- ☐ Full-duty release
- ☐ Limited duty release (indicate restriction(s) and applicable dates)
  - ☐ Lifting restriction of \_\_\_\_\_lbs.
  - ☐ Working no more than \_\_\_\_\_hours per day, \_\_\_\_\_days per week.
  - ☐ Standing or walking no more than \_\_\_\_\_minutes at a time.
  - ☐ No driving or using heavy machinery.
  - ☐ No performing activities requiring concentration or significant decision making.
  - ☐ Other (please list below in detail).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type of Practice (field of specialization, if any)

\_\_\_\_\_  
Phone #

# Loudoun County Government

## Long Term Disability Benefit Highlights

|   |  |
|---|--|
| <b>Eligibility</b>                                      | Regular active employees who work for Loudoun County Government.   |
| <b>Coverage Effective Date</b>                          | January 1 <sup>st</sup> , 2006   |
| <b>Benefit Percentage &amp; Maximum Monthly Benefit</b> | <p>Your Long Term Disability (LTD) plan replaces 67% of your monthly income loss, subject to a maximum of \$8,000.</p> <p>You have the opportunity to increase this coverage and have income protection to replace up to 67% of your regular pay to a maximum monthly benefit of \$10,000 by enrolling in Loudoun County Government's LTD Buy-Up plan.</p>   |
| <b>Minimum Monthly Benefit</b>                          | Your minimum monthly LTD benefit is the greater of \$100 or 10% of the gross disability benefit.   |
| <b>Elimination Period</b>                               | You must be disabled for 60 days before benefits may be payable.   |
| <b>Benefit Duration – Core Plan</b>                     | 12 months  |
| <b>Benefit Duration – Buy up Plan</b>                   | 36 months  |
| <b>Guaranteed Issue Amount</b>                          | The guaranteed issue amount is the amount of insurance that you are eligible for without providing evidence of good health. If you enroll during this enrollment period, your LTD coverage is provided to you on a guaranteed issue basis – <u>no medical information is required</u> . If you enroll after this enrollment period, evidence of good health will be required for all coverage amounts.   |
| <b>Definition of Disability</b>                         | Disability or disabled means that, during the elimination period and for the next 12 months, you are prevented by accidental bodily injury, sickness, mental illness, substance abuse or pregnancy from performing one or more of the essential duties of your occupation, and as a result, your current monthly earnings are no more than 80% of your pre-disability earnings. After that, you must be prevented from performing one or more of the essential duties of any occupation. |
| <b>Definition of Earnings</b>                           | Your earnings are defined as your regular monthly rate of pay from Loudoun County Government just prior to your date of disability – excluding commissions, bonuses, overtime pay or any other fringe benefit or extra compensation.   |
| <b>Survivor Income Benefit</b>                          | The Survivor Income Benefit pays a lump-sum, six-month benefit to your surviving spouse (or your children in equal shares if there is no surviving spouse) if you die while receiving LTD benefits. If there are no survivors, the benefit will be paid to your estate.  |
| <b>Mental Illness, Alcoholism and Substance Abuse</b>   | Benefits resulting from mental illness, alcoholism and substance abuse are limited to a total of 24 months for all disability periods during your lifetime. This limitation does not apply to periods of confinement in a hospital or other facility licensed to provide medical care for the disabling condition.   |
| <b>Pre-Existing Conditions</b>                          | Benefits are not payable for medical conditions for which you received care during the 90 days preceding the date your plan goes into effect, unless you have received no further treatment for that condition for 90 consecutive days from the date your coverage begins, or your total disability begins on or after the last day of a 365 day period during which you have been insured under this plan.  |
| <b>Other Income Benefits</b>                            | Your monthly LTD benefit will be reduced by other income benefits you or your family receives or is eligible to receive. These benefits include but are not limited to the following: Workers' Compensation benefits; Social Security Disability benefits; other group, association, union or other organizational coverage; and governmental laws or programs that provide disability or unemployment benefits as a result of your job with Loudoun County Government.                  |
| <b>Taxability</b>                                       | The portion of your benefit that is paid for by you is not subject to income tax.  |
| <b>Participation Requirement</b>                        | Hartford Life requires that a minimum of 25% of eligible employees participate in this plan in order to offer this coverage.   |

## Key Terms

**Long-Term Disability Exclusions:** Benefits are not payable for disabilities resulting from any of the following war or act of war (declared or not) or, the commission or attempt to commit a felony. In addition, your plan may exclude a disability caused or contributed to by an intentionally self-inflicted injury. Benefits are not payable if you are not under the regular care of a physician.

**Pre-existing Condition Limitation:** If your plan has a pre-existing condition limitation, any disability due to a condition for which you were diagnosed or received care before the effective date of your plan will only be covered in one of three situations. The first is that there has been a treatment-free period (the length of time specified in your plan) since your effective date. The second is that even if you're receiving treatment, you would be eligible to receive benefits if the disability begins after you've been insured for a designated period. The third is that you have already satisfied the pre-existing condition requirement of a prior insurer. The specific length of either the treatment-free period of the insured period can be found on your Benefit Highlight Sheet.

**Benefit Amount offsets:** Your Long-Term Disability benefit amount will be reduced by other income benefits you (or possibly your family) receive or are eligible to receive. Examples of such "other income benefits" are income from Social Security Disability Insurance, the Civil Service Retirement System, Railroad Retirement Act, the Jones Act, Canada Pension Plan, the Veteran's Administration, Workers' Compensation or occupational disease laws; group, association, union or other organizational coverage; employer-related individual policies; any disability or unemployment benefits; damages or settlements for income loss; and compulsory no-fault automobile plans.

For Long-Term Disability Benefits Amounts, retirement benefits are another example of "other income benefits" of the retirement plan is wholly or partially funded by employer contributions, unless you were receiving them prior to becoming disabled, or you immediately transfer the payment to other plan qualified by the U.S. Internal Revenue Service for the funding of a future retirement.

Your Long-Term Disability benefit payments will not be reduced by retirement benefits from Social Security Disability Insurance or similar plans, or by any portion of retirement benefits that you (or your family depending on your plan) receive that are funded by your after-tax contributions.

Your Long-Term Disability benefit payments will not be reduced by your savings or investments, IRAs or Keoghs, profit-sharing, personal disability policies or Social Security Increases.

**Late Entrant:** Previously eligible employees who did not enroll during their initial 31 day eligibility period are considered Late Entrants. Late Entrants may be responsible to pay for the cost of physical exams, medical records or medical tests if they are required.

This Benefit Highlights Sheet explains the general purposes of the insurance described, but in no way change or affect the policy as actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with your other important papers.

---

Underwritten by:  
Hartford Life and Accident Insurance Company  
200 Hopmeadow Street  
Simsbury, CT 06089

Administered by:



Underwriting Company\* (herein called the "Company"):

- ☐ CNA Group Life Assurance Company  
☐ Continental Casualty Company

**LTD EMPLOYER'S STATEMENT**

For assistance call: 1-800-303-9744

**INSTRUCTIONS TO EMPLOYER:** Complete the Employer's Statement & attach job description. Instruct employee to complete Employee's Statement and have Physician's Statement completed. Unless otherwise notified by The Hartford, Employers/Benefit Administrators should refer to their Administrative Manuals for the current claim office address. Please mail the forms so that they **ARRIVE** at least 30 days before the end of the elimination period.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| Name (Last, first, middle initial)   |  | Telephone No. (Include Area Code)<br>( )  |  | Date of Birth   |  |
| Address (Street number, city, state, zip code)   |  |   |  |   |  |
| Date Employed  |  | Effective Date of LTD Coverage  |  | SSN   |  |
| Employee Class   |  |   |  |   |  |
| Percentage of Employer Contribution Toward Disability Premium: %   |  | LTD Premium paid with<br><input type="checkbox"/> Pre Tax <input type="checkbox"/> Post Tax   |  | Is the employee's LTD coverage continuous since the original effective date? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| How is the employee paid?<br><input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Salary Plus Bonus <input type="checkbox"/> Monthly<br><input type="checkbox"/> Commissions Only <input type="checkbox"/> Other:                            |  | Pay Frequency:<br><input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly<br><input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly        |  |   |  |
| Basic Earnings as of last day worked:  |  | Number of regularly scheduled hours per week:   |  | Effective date of reported salary or wage:  |  |
|  |  |   |  | Occupation  |  |
| Duties: (include physical activities, hazards and skills required.) <b>Attach job activities statement or job description.</b>   |  |   |  |   |  |
|  |  |   |  |   |  |
| Date last worked prior to current disability   |  | Has Employee worked part-time or partial duties since disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>(If Yes, explain on reverse side) |  |   |  |
| Is disability due to injury or sickness arising out of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, send copy of Report of injury form.)  |  | Has employee retired? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  | Has employee terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| If Yes, Input Date: / /  |  |   |  |   |  |
| Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  | Amount of Benefits \$ Per   |  | Date Benefits Began   |  |
|  |  |   |  | Date Benefits Paid Through  |  |
| Name and Address of Workers' Compensation Carrier  |  |   |  |   |  |
| W/C Claim #:   |  | Adjuster:   |  | Phone #:  |  |
| Please indicate any benefits your employee has received or is entitled to receive during this disability. This would include but not be limited to company sponsored short-term benefits. State disability benefits, sick pay, salary continuance, commissions and / or bonuses. |  |   |  |   |  |
| <input type="checkbox"/> Sick Pay <input type="checkbox"/> State Disability Income <input type="checkbox"/> STD <input type="checkbox"/> Other Sources (Explain):  |  |   |  |   |  |
| <input type="checkbox"/> Amount d Benefits: \$ Per   |  |   |  |   |  |
| Date Benefit Began   |  | Date Benefit Paid Through   |  | If more than one source, please list on back.   |  |
|  |  |   |  |   |  |
| Employer / Policy Holder's Name  |  | Policy Number   |  | Telephone No.<br>( )  |  |
| Address (Street number, city, state, zip code)   |  |   |  |   |  |
| Completed By (Signature)   |  | Title   |  | Date  |  |

\* The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company, Hartford Life Insurance Company and CNA Group Life Assurance Company (pending state approval of name change to "Hartford Life Group Insurance Company").

Administered by:



Underwriting Company\* (herein called the "Company"):

- ☐ CNA Group Life Assurance Company  
☐ Continental Casualty Company

# LTD EMPLOYEE'S STATEMENT

For assistance call: 1-800-303-9744

Use back to answer any questions where space does not permit. Return form to Employer.

Company Name

|  |                                   |                        |
|--|-----------------------------------|------------------------|
| Name (Last, first, middle initial)   | Telephone No. (Include Area Code) | Date of Birth          |
| Home Address (Street number, city, state, zip code)                                    |                                   | Social Security Number |
| Mailing Address, if different from Home Address (Street number, city, state, zip code) |                                   |                        |

|  |  |                              |                                   |
|--|--|------------------------------|-----------------------------------|
| Marital Status<br><input type="checkbox"/> Single <input type="checkbox"/> Married<br><input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | If married, Spouse's Name & Birth Date | Number of Dependent Children | Birth Date of Youngest Dependent: |
|--|--|------------------------------|-----------------------------------|

| Have you applied for or are you receiving benefits from: | Applied                  |                          | Receiving                |                          | Date Applied For | Amount Received |         | Effective Date | Paid Thru Date |
|--|--------------------------|--------------------------|--------------------------|--------------------------|------------------|-----------------|---------|----------------|----------------|
|  | Yes                      | No                       | Yes                      | No                       |                  | Weekly          | Monthly |                |                |
| a. Social Security                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |                |
| b. Workers' Compensation                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |                |
| c. State Disability Insurance                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |                |
| d. Retirement or Pension                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |                |
| e. Other   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                  |                 |         |                |                |

\*Please Attach copies of letters or notices related to these Other Benefits

|  |  |   |
|--|--|---|
| If due to injury, how and when did this accident occur?      |  | Date first treated for this sickness or injury:                   |
| How does sickness/injury prevent you from returning to work? | Date last worked prior to current sickness/injury: | On what date were you able to or do you expect to return to work? |

List primary physicians you consulted because of this disability. (Use other side if necessary)

| Physician's Name | Address & Phone No. (Including Area Code) | Dates Treated |
|------------------|---|---------------|
| 1.               | 1.  | 1.            |
| 2.               | 2.  | 2.            |
| 3.               | 3.  | 3.            |
| 4.               | 4.  | 4.            |

List all hospital confinements for this disability. (Use other side if necessary)

| Name of Hospital | Address | Date Confined |
|------------------|---------|---------------|
| 1.               | 1.      | 1.            |
| 2.               | 2.      | 2.            |
| 3.               | 3.      | 3.            |
| 4.               | 4.      | 4.            |

**IMPORTANT: THE FOLLOWING AUTHORIZATION MUST BE COMPLETED BY THE EMPLOYEE:**

I AUTHORIZE The Hartford to release all of its collected health and financial information concerning me, including medical record information, for the purpose of evaluating my claim(s) for Life, Accident, or Disability Income benefits administered or insured by the The Hartford. I AUTHORIZE The Hartford to provide a complete copy of my claim file and/or information concerning my health and finances, claim status, or summaries thereof, to my employer through the appropriate employee benefit/human resources coordinators for the purpose of processing my claim(s) or for the proper administration of the employer's group benefit plan, including any disclosures which may be needed in order to facilitate my return to work with my employer. I further Authorize The Hartford to disclose any collected health or financial information, including medical record

information, to my employer's Workers' Compensation carrier, in the event I file a Workers' Compensation claim and such information is requested of The Hartford. I UNDERSTAND that I may receive a copy of this authorization and that this authorization is valid for the entire duration of my claim. I UNDERSTAND that I may revoke this Authorization at any time by providing written notice to The Hartford, except to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation. I AGREE that a photographic copy of this authorization shall be as valid as the original.

| Name (Please Print) | Signature | Date Signed |
|---------------------|-----------|-------------|
|---------------------|-----------|-------------|

"Information Provider" as used herein may include any physician, medical practitioner, hospital, clinic, other medical or medically related facility, health plan, insurance or reinsuring company, agent, Health Claims Index, credit bureau or other consumer reporting agency, employer or employer benefit plan, Medical Information Bureau (MIB), Social Security Administration, Educational Institution, Government Agency or the Veterans Administration.

"Information" received from an Information Provider concerning the patient/claimant may include information relating to any advice, diagnosis, prognosis, treatment or care of my physical or mental condition, including information about any illness or injury, consultations, prescriptions or treatment, including x-ray plates and hospital records, records of drug or alcohol abuse and treatment, communicable disease, Human Immunodeficiency Virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease, mental illness (except psychotherapy notes), and/or financial, consumer report, or any other non-medical information regarding me.

I AUTHORIZE any Information Provider to give the Company, its legal representatives, its affiliated companies or its reinsurers, any and all Information regardless of any previous restriction or limitation on disclosure of such Information.

I UNDERSTAND that:

- the information obtained by use of this Authorization is at my request and will be collected by the Company to evaluate my claim for life, accident, and/or disability income benefits for which I may be entitled. I understand that benefits may be provided by a policy of insurance issued by the Company, or, as applicable, by a benefit plan provided by my employer for which the Company provides administrative services only. I understand that the information obtained by use of this Authorization may be used to administer any feature described in the policy of insurance or employer benefit plan, including evaluating return to employment opportunities with my employer.
- I understand that if I refuse to sign this Authorization it will not affect my ability to receive treatment from my physician or other healthcare provider.
- this Authorization shall remain valid for the duration of the claim.
- I may revoke this Authorization at any time by providing written notice to the Company, except to the extent that an individual has taken action in reliance upon such authorization prior to notice of the revocation.
- the Company may maintain or have access to personal information acquired separately through any of my insurance applications with the Company. I authorize the Company to use such information for evaluation of my claim.
- information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer the responsibility of the Information Provider or protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I may request to receive a copy of this Authorization and I agree that a photographic copy of this Authorization shall be as valid as the original.

| Name (Please Print) | Signature | Date Signed |
|---------------------|-----------|-------------|
|---------------------|-----------|-------------|

**\*\*IMPORTANT NOTICE\*\***

**RESIDENTS OF ALL STATES EXCEPT AZ, CA, FL, NH & NJ:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or settlement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**AZ Residents:** For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**CA Residents:** For your protection California law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**FL Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**NH Residents:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NJ Residents:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Administered by:



Underwriting Company\* (herein called the "Company"):

- ☐ CNA Group Life Assurance Company  
☐ Continental Casualty Company

## LTD PHYSICIAN'S STATEMENT

For assistance call: 1-800-303-9744

**PLEASE PRINT** – Use a separate sheet of paper to answer questions where space does not permit.

|   |                                |
|---|--------------------------------|
| Patient's Name                                    | Date of Birth                  |
| Patient's Address – Street, City, State, Zip Code | Phone Number (Area Code First) |
| Employer's Name                                   | Policy Number                  |

I hereby authorize release of information on this form, by the physician name on the second page or reverse side of this form for the purpose of claim processing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### 1. HISTORY

- (a) When did symptoms first appear or accident happen? Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (b) Date of first visit: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (c) Date you first advised patient to cease work: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (d) Has patient ever had same or similar condition? ☐ Yes ☐ No  
If yes, please state when and describe:
- (e) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

### 2. MEDICAL CONDITION

- (a) Diagnosis:
- (b) Complications:
- (c) Symptoms:
- (d) OBJECTIVE FINDINGS (Please attach reports including x-rays, EKG's, Lab Data and any clinical findings):

### 3. NATURE OF TREATMENT

- (a) What are the treatment plans?
- (b) Surgery:
- (c) Medications:
- (d) Has this person been referred to another physician? ☐ Yes ☐ No  
Name, address, phone & Fax # of this physician:
- (e) Date of last visit: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_
- (f) Is further treatment required?

**4. PHYSICAL LIMITATIONS**

What are the specific limitations (i.e., lifting, standing, stooping)

5. Does this person have mental or nervous limitations? ☐ Yes ☐ No  
If yes, please describe:

5. PROGNOSIS (Recovery and return to work date)

REMARKS:

|   |           |                       |
|---|-----------|-----------------------|
| Name (Physician) Please Print                               | Specialty | Telephone<br>(      ) |
| Address – Street, City or Town, State or Province, Zip Code |           | Fax<br>(      )       |
| Signature   |           | Date                  |

\* The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life and Accident Insurance Company, Hartford Life Insurance Company and CNA Group Life Assurance Company (pending state approval of name change to "Hartford Life Group Insurance Company").

Please return to Claimant.  
For Assistance Call: 1-800-303-9744

## **EMPLOYEE ASSISTANCE PROGRAM**

- What is EAP?

The Employee Assistance Program, or EAP, for Loudoun County Government employees provides confidential assistance as related to problems or issues which are affecting the employee at home, at work, or in any area of life.

- What does the EAP do?

EAP services include assessment and referral for mental health counseling, substance abuse counseling, and/or other community resources as appropriate to the employee's needs.

Employees who are in crisis may be referred for Emergency Services (703-777-0320).

- Who is eligible?

EAP services are available from Loudoun County Mental Health for permanent and temporary, full-time and part-time Loudoun County Government employees and any immediate family members who reside in the same household as the employee.

- What do EAP services cost?

There is no direct cost to the employee for EAP services.

Since 1981, Loudoun County Mental Health has provided EAP services as an employee benefit by agreement with Loudoun County Government.

For more information or to arrange for services, contact:

Carrie Cecca, LPC  
Loudoun County Mental Health  
703-771-5100



# **Supervisor's Responsibilities**

## **Quick Reference Guide**

- 1) Provide injured employee with an *Accident Report Packet* once you are aware that an incident/accident has occurred.
- 2) Have the employee complete an *Employee's Report of Injury*, review and sign.
- 3) You will need to complete the *Employer's Accident Report* and submit along with witness statements and the *Employee's Report of Injury* to Tom Chunta, Workers' Compensation Coordinator in the Benefits Department.
- 4) If the employee needs to seek medical treatment you should provide or coordinate transportation for the employee; if the injury is severe, please call 911 immediately for an ambulance.
- 5) If the employee's injury results in any lost work time, you must notify Tom Chunta, Workers' Compensation Coordinator immediately.
- 6) You should provide a copy of the injured employee's most recent performance plan for the employee's follow-up doctor's visit for all lost time injuries.
- 7) Time sheets (iforms for exempt employees) should reflect lost time that is due to a work related injury or illness. Time sheets must be submitted to Tom Chunta, Workers' Compensation Coordinator in advance of the payroll deadline for approval.
- 8) You are encouraged to keep in contact the employee on a regular basis to obtain updates on their condition and potential return to work status.
- 9) The injured employee should provide you a copy of all subsequent paperwork from any follow-up doctor's/ physical therapy appointments and off work, restricted duty or return to work slips. A copy of documents should also be forwarded to Tom Chunta in the Benefits Department. Restricted duty releases must be evaluated by both supervisor / department head and the County's Workers Compensation Coordinator in advance of the employee's return to work. We recommend that you provide a copy of the employee's performance plan to the employee to take to their initial follow-up appointment from a lost time injury.
- 10) Times for follow-up physician appointments and physical therapy must be coordinated between the employee and their supervisor so as to not unduly disrupt the workplace. If you are unable to come to agreement with the employee on his/her appointment schedule, please contact Tom Chunta for assistance.

11) Upon the employee returning to work, please obtain a copy of all information the employee received from the treating physician and/or medical facility and forward to Tom Chunta in the Benefits Department.

If you should have any questions regarding workers' compensation procedures or your responsibilities, please contact Tom Chunta, Workers' Compensation Coordinator at 703.777.0214. You may also contact Human Resources at 703.777.0213 or the Benefits Help Line at 703.777.0517.

**Employer's Accident Report**  
(formerly: Employer's First Report of Accident)  
Virginia Workers' Compensation Commission  
1000 DMV Drive Richmond VA 23220  
*See instructions on the reverse of this form*

|  |                                       |                         |
|--|---------------------------------------|-------------------------|
| <b>The boxes<br/>to the right<br/>are for the<br/>use of the<br/>insurer</b> | Reason for filing                     | VWC file number         |
|  | Insurer code or PEO Ref. No.<br>90267 | Insurer location<br>760 |
|  | Insurer claim number                  |                         |

|  |  |   |                        |   |
|--|--|---|------------------------|---|
| <b>Employer</b>  |  |   |                        |   |
| 1. Name of employer (trading as or doing business as, if applicable)<br>County of Loudoun, VA                |  | 2. Federal Tax Identification Number<br>54-0948306  |                        | 3. Employer's Case No. (if applicable)  |
| 4. Mailing address<br>P.O. Box 7000, 1 Harrison St., SE<br>Leesburg, VA 20177                                |  | 5. Location (if different from mailing address)   |                        |   |
| 6. Parent corporation /Policy Named Insured (if applicable) or PEO name                                      |  | 7. Nature of business<br>County Government  |                        |   |
| 8. Name and Address of Insurer or self-insurer for this claim<br>Wells Fargo Disability Management           |  | 9. Policy number  |                        | 10. Effective date  |
| <b>Time and Place of Accident</b>  |  |   |                        |   |
| 11. City or county where accident occurred   | 12. Date of injury   | 13. Hour of injury<br>a.m. p.m.<br>13a. Time began work<br>a.m. p.m.  | 14. Date of incapacity | 15. Hour of incapacity  |
| 16. Was employee paid in full for day of injury?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 17. Was employee paid in full for day incapacity began?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                        |   |
| 18. Date injury or illness reported  | 19. Person to whom reported  | 20. Name of other witness   |                        | 21. If fatal, give date of death  |
| <b>Employee</b>  |  |   |                        |   |
| 22. Name of employee (Last, First, Middle)   |  | 23. Phone number  |                        | 24. Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female  |
| 25. Address  |  | 26. Date of birth   |                        | 27. Marital status<br><input type="checkbox"/> Single <input type="checkbox"/> Divorced<br><input type="checkbox"/> Married <input type="checkbox"/> Widowed                                      |
| 29. Occupation at time of injury or illness  |  | 30. Is worker covered by PEO policy?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                        | 31. Number of dependent children  |
| 32. How long in current job?   | 33. Date of Hire   | 34. Was employee paid on a piece work or hourly basis?<br><input type="checkbox"/> Piece work <input type="checkbox"/> Hourly                                   |                        |   |
| 35. Hours worked<br>per day  | 36. Days worked<br>per week  | 37. Value of perquisites per week<br>Food/meals      Lodging      Tips      Other<br>\$                      \$                      \$                      \$ |                        |   |
| 38. Wages per hour<br>\$   | 39. Earnings per week (inc. overtime)<br>\$  |   |                        |   |
| <b>Nature and Cause of Accident</b>  |  |   |                        |   |
| 40. Machine, tool, or object causing injury or illness   |  | 41. Specify part of machine, etc.   |                        |   |
| 42. Describe fully how injury or illness occurred  |  |   |                        |   |
| 43. Describe nature of injury or illness, including parts of body affected                                   |  |   |                        | 43a. Overnight inpatient hospitalization?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>43b. Treated in Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 44. Physician (name and address)   |  | 45. Hospital or Clinic (name and address)   |                        |   |
| 46. Probable length of disability  | 47. Has employee returned to work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | If yes  | 48. At what wage?      | 49. On what date?   |
| 50. EMPLOYER: prepared by (name, signature, title)   |  | 51. Date  |                        | 52. Phone number  |
| 53. INSURER: (name of processor)   |  | 54. Date  |                        | 55. Phone number  |
| 56. THIRD PARTY ADMINISTRATOR (if applicable)  |  | 57. Address   |                        | 58. Phone number  |

## INSTRUCTIONS

### Employer's Accident Report (formerly Employer's First Report of Accident) VWC Form No. 3

#### Employer

1. Fill out this form whenever one of your employees is injured. Provide all the information requested, except the information in the top right corner. **Please type or print all information in black ink.** Your signature is required on line 50 of the form.
2. Send the original beige form to your insurance carrier, claims servicing agency, or third party administrator for processing. If you are self-insured, send it to your organization's designated office for handling workers' compensation claims.
3. If you are an employer subject to OSHA record-keeping requirements, you may retain a copy of this completed form as a supplementary record of occupational injury or illness. Use block #3 (Employer's Case No.) to cross-reference your master log of accidents and illnesses.
4. If you need additional copies of this form, please request them from your insurance carrier, claims servicing agency, or third party administrator.

#### Insurance carriers, self-insured employers, Professional Employer Organizations (PEO's), and authorized representatives

1. For accidents meeting one of the seven criteria for establishing a Commission Case File,\* submit the original beige form and one copy to the Virginia Workers' Compensation Commission at 1000 DMV Drive, Richmond VA 23220. The code for the reason for filing should be written at the top right of the form.
2. When processing these forms prior to transmittal to the Commission, please include the information requested at the top right of the form, verify that the carrier name and policy number given by the employer are accurate, and enter your name and phone number, and the date of processing at the bottom of the form.
3. Insurer code at the top right of the form refers to the five-digit code assigned by NCCI. If you are self-insured, it refers to a similar five-digit number assigned by the Virginia Workers' Compensation Commission. A PEO must use the VWCC reference number.
4. Additional copies of this form are available without cost by writing to the Commission. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. Write to "Forms" at the listed Virginia Workers' Compensation Commission address.
5. On Lines 8 and 9, the employer or carrier is to give the name of the responsible carrier as set forth on the policy (line 8) and that carrier's policy number (line 9).

\*The criteria are (1) lost time exceeds seven days, (2) medical expenses exceed \$1,000, (3) compensability is denied, (4) issues are disputed, (5) accident resulted in death, (6) permanent disability or disfigurement may be involved, and (7) a specific request is made by the Virginia Workers' Compensation Commission.